

11954

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Myersville</i>	LENGTH OF STAY (in this place) <i>life</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Myersville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <i>John</i>	(Middle) <i>N.</i>	(Last) <i>Adkins</i>	<i>12 - 20 - 1955</i>
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>6-24-1877</i>
9. AGE last birthday: <i>78</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>day laborer</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>John Adkins</i>		14. MOTHER'S MAIDEN NAME: <i>Amanda Lewis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Mrs. Mary Adkins, Myersville, Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Acute myelogenous leukemia</i>		<i>1 mo.</i>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10/14</i> , 1955 to <i>12/21</i> , 1955 that I last saw the deceased alive on <i>12/21</i> , 1955, and that death occurred at <i>7:25 P.</i> from the causes and on the date stated above.			
SIGNATURE <i>Euneth C. Benson</i>		DATE SIGNED <i>12/22/55</i>	
ADDRESS <i>Middletown</i>			
M.D. <i>Middletown</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-24-1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Harmony Cemetery</i>		LOCATION (City, town, or county) (State) <i>Frederick Co., Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Dec. 23, 1955</i>		REGISTRAR'S SIGNATURE <i>Floy M. Bittle</i>	
24. FUNERAL DIRECTOR <i>Gladhill Co., Middletown, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 27 1955

RECEIVED

11955 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Frederick</u>
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Rural Middletown</u>	<u>30 years</u>	<u>Rural Middletown</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Sadie</u>	(Middle) <u>F.</u>	(Last) <u>Alexander</u>	OF DEATH: <u>12</u> <u>8</u> <u>1955</u>
(Type or Print)			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>married</u>	<u>12-21-1880</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>74</u> yrs.	Months	Days	Hours
			Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>housewife</u>		<u>own home</u>	<u>Maryland</u>
13. FATHER'S NAME:		12. CITIZEN OF WHAT COUNTRY?	
<u>Ezra Haupt</u>		<u>U.S.</u>	
14. MOTHER'S MAIDEN NAME:		17. INFORMANT & ADDRESS:	
<u>Lillie Doat</u>		<u>Lawson C. Alexander, Middletown, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Diabetes Mellitus</u>			<u>June 1951</u>
ANTECEDENT CAUSE (B) <u>Chronic myocarditis</u>			<u>4</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>51</u> , to <u>Dec 5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>55</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Elizabeth Mader</u>		DATE SIGNED <u>12-8-55</u>	
M. D. <u>1 Baunshaus, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>12-11-1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Reformed Cemetery</u>		<u>Middletown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>12-10-1955</u>		<u>Elizabeth S. Heck</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Gladhill Co.</u>		<u>Middletown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. P.

DEC 12 1955

RECEIVED

11925

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11927

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Emmitsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>R.D. 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna Ruth BAKER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>DEC 3 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, <del>OR</del> <u>Widowed</u>		8. DATE OF BIRTH: <u>July 24, 1887</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		9. AGE last birthday: <u>68</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Frederick Co. Maryland</u>	
13. FATHER'S NAME: <u>Robert Wetzel</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Miss Ben Wetzel, Emmitsburg, Md. R.D. 2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>10 days</u>	
ANTECEDENT CAUSE (B) <u>Chronic Pyelonephritis</u>						<u>? years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>14 NOV, 1955</u> , to <u>3 DEC, 1955</u> , that I last saw the deceased alive on <u>3 DEC, 1955</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Conley Jr.</u>				ADDRESS <u>M.D. Frederick, Maryland</u>		DATE SIGNED <u>12/3/55</u>	
23. BURIAL, CREMATION, REMOVE (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Eliza Lutheran Church</u>		LOCATION (City, town, or county) (State) <u>Emmitsburg, Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. H. H. H.</u>		24. FUNERAL DIRECTOR <u>R. L. Allison</u>		ADDRESS <u>Emmitsburg, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH  
11928 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

11926

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Frederick</u> <u>10 Lincoln Apt. Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>10 Lincoln APT.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Bertha Madeline Barnes</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 20 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>3-24-1895</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Cleaning</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Ann Frances Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Mrs. Marie Thomas, 4 South St. - Frederick</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.3 Immediate cause (a) <u>Angina pectoris</u>						<u>2 hours</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Street</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
				(CITY OR TOWN) <u>Frederick</u>		(COUNTY) <u>Frederick</u> (STATE) <u>MD</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>R. C. Hermann, M.D. Deputy Medical Examiner</u>				ADDRESS <u>Frederick</u>		DATE SIGNED <u>Dec 22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-23-1955</u>		<u>St. Johns Cemetery</u>		<u>Frederick - Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>22 Dec. 1955</u>		<u>Elizabeth L. Heals</u>		<u>C. E. Glime &amp; Son - Frederick - Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 27 1955

BUREAU V. S.



11929

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 Frederick		LENGTH OF STAY (in this place) 78 Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick 11			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Crutchley Nursing Home				STREET ADDRESS (If rural give location) 24 West South Street 1			
3. NAME OF DECEASED: (First) ANNIE (Middle) ELIZABETH (Last) BENNETT				4. DATE (Month) (Day) (Year) OF DEATH: December 13, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: May 25, 1872	
9. AGE last birthday: 83 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		11. BIRTHPLACE (State or foreign country): West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: John S. Hartman		14. MOTHER'S MAIDEN NAME: Annie Elizabeth Full		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mrs. Annie E. Kroh, 330 East Third Street, Frederick, Maryland		18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) 332X Broucho pneumonia				2 days			
ANTECEDENT CAUSE (B) DUE TO Cerebral artery thrombosis				10 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. 260X				(C) Diabetes mellitus			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				6 years			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb., 1955, to Dec. 13, 1955, that I last saw the deceased alive on Dec. 13, 1955, and that death occurred at 5:20 P.M. from the causes and on the date stated above.							
SIGNATURE J. R. Scherbaum		M. D. Frederick, Maryland		DATE SIGNED 12/14/1955			
23. BURIAL, CREMATION, REMOVAL Burial		DATE THEREOF Dec. 17, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 15 Dec. 1955		REGISTRAR'S SIGNATURE Elizabeth B. Heath		24. FUNERAL DIRECTOR M.R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 16 1955

RECEIVED

11930

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Frederick		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 307 West Second Street				STREET ADDRESS (If rural give location) 307 West Second Street			
3. NAME OF DECEASED: (First) ADDIE		(Middle) RUTH		(Last) BLACKWELL		4. DATE OF DEATH: December 26 1955	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: June 13, 1893	
9. AGE last birthday: 62 yrs.		10. KIND OF BUSINESS OR INDUSTRY: Own home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Murray Lambert				14. MOTHER'S MAIDEN NAME: Mary Elizabeth Mussetter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mr. Paul Blackwell - 307 W. 2nd St., Frederick Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.							
Immediate cause (a) Cerebral vascular accident							
Antecedent causes (s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1, 1953, to Dec 1, 1955, that I last saw the deceased alive on 12-20, 1955, and that death occurred at 7:00 A.M., from the causes and on the date stated above.							
SIGNATURE <i>Paul Blackwell</i>				ADDRESS 35 E Church Frederick Md		DATE SIGNED 12-27-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Dec. 29, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 21 Dec. 1955		REGISTRAR'S SIGNATURE <i>Elizabeth B. Hack</i>		24. FUNERAL DIRECTOR C. E. Cline & Son - Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

11929

11931

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH— COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 Klineharts Alley		STREET ADDRESS (If rural, give location) 413 Klineharts Alley	
3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) WILLIAM	(Last) BLANK
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 16 June 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day Laborer	9. AGE last birthday 68 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Blank		14. MOTHER'S MAIDEN NAME Martha Hart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 219-20-0600	
17. INFORMANT AND ADDRESS Mrs. Lillie M. Blank, Frederick, Md.		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 220

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

9 Dec 1955

Elizabeth B. Heub

M. R. Etchison &amp; Son, Frederick, Md.

RECEIVED  
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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11956

## CERTIFICATE OF DEATH

11930

131

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick-Rural RD#1	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick-Rural RD#1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mount Pleasant		STREET ADDRESS (If rural give location) Mount Pleasant	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) VERA (Middle) GRACE (Last) CRAMER		(Month) December (Day) 29 (Year) 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH January 15, 1890
		9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Herman A. Buckey		14. MOTHER'S MAIDEN NAME Margaret E. Nusbaum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
		17. INFORMANT & ADDRESS Mr. S. Clarence Cramer, Frederick R.D.#1, Md	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Adenocarcinoma</i>			Year
ANTECEDENT CAUSE(S) DUE TO (B) <i>metastases to Lung &amp;</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>abdomen, pancreas, stomach</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 55, to Dec 29, 19 55, that I last saw the deceased alive on Dec 29, 19 55, and that death occurred at 12 PM M, from the causes and on the date stated above.			
SIGNATURE <i>B. Thomas</i> M.D. Frederick, Maryland		ADDRESS (Street, city, town, state) DATE SIGNED 30 Dec 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Jan. 2, 1956	NAME OF CEMETERY OR CREMATORY Glade Cemetery	LOCATION (City, town, or county) Walkersville, Maryland
24. REC'D BY REGISTRAR DATE 3 Dec. 1956	REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland	



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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11931

11957

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#5</b>		LENGTH OF STAY (in this place) <b>2 Weeks</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Montevue</b>		STREET ADDRESS (If rural give location) <b>Yellow Springs</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>GEORGE WILLIAM CREBBS</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 17, 1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>7 July 1875</b>	<b>9. AGE last birthday</b> <b>80</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Day Laborer</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John B. Crebbs</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Holtzapple</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, give year or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Elmer R. Crebbs, RD#3, Frederick, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>422.1 IMMEDIATE CAUSE (A)</b> <b>Chronic myocarditis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Unk.</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arterio-sclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 12:00 P.M., 1955, to 12:00 P.M., 1955, that I last saw the deceased alive on 12:00 P.M., 1955, and that death occurred at 11:30 A.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>H. H. H.</i>				<b>ADDRESS (Street, city, town, state)</b> <b>Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>19 Dec 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>20 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Pleasant Hill Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Near Yellow Springs, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>20 Dec 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elizabeth C. Heck</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

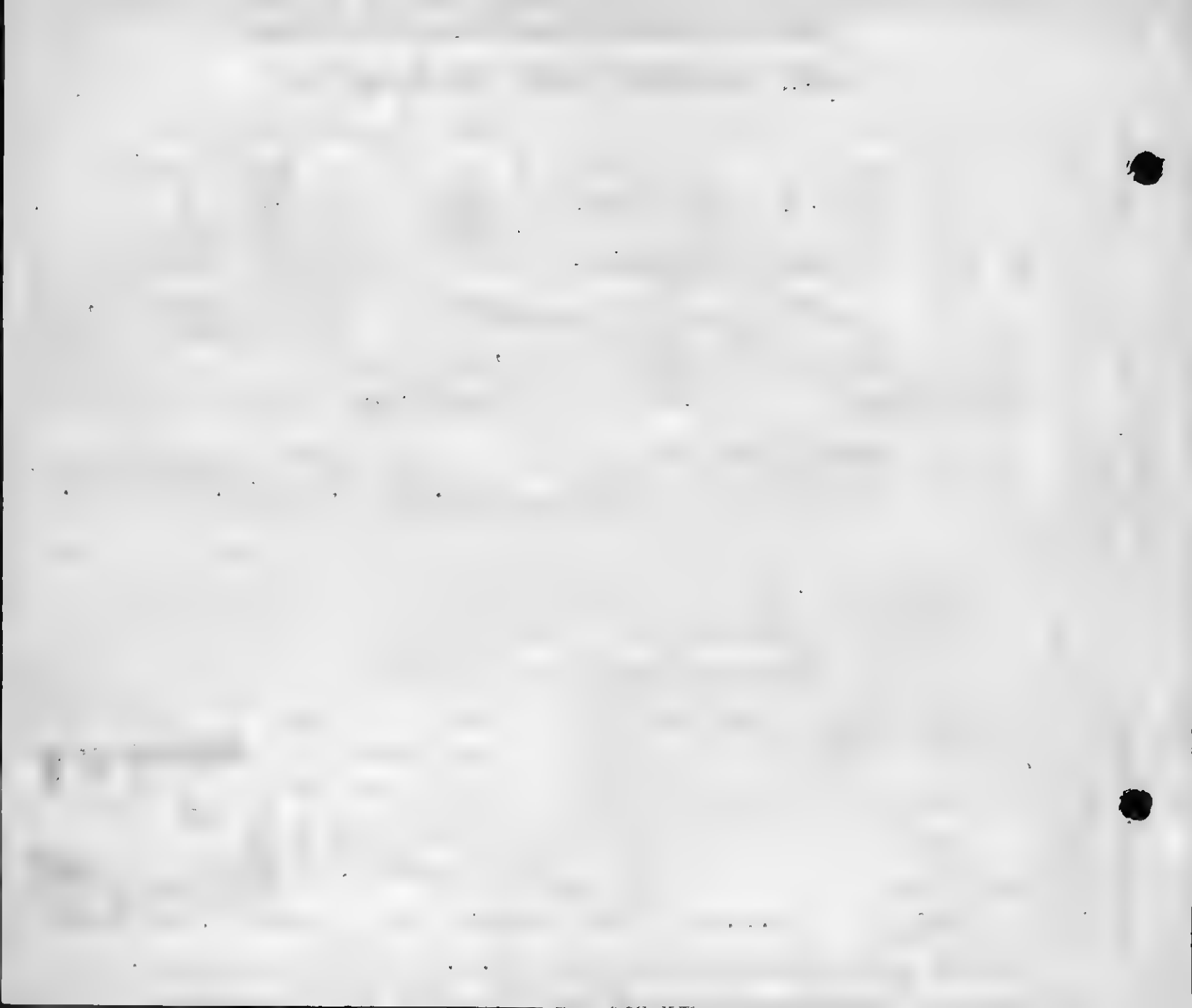
11932

## CERTIFICATE OF DEATH

11932

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>Maryland</b> COUNTY <b>Frederick</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Years</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>		STREET ADDRESS (If rural give location) <b>450 West South Street</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		TOWN <b>Frederick</b>	
<b>3. NAME OF DECEASED</b> (First) <b>MEHRL</b> (Middle) <b>COLUMBUS</b> (Last) <b>CRUMMITT</b>				<b>4. DATE OF DEATH</b> (Month) <b>December</b> (Day) <b>15</b> (Year) <b>1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 29, 1892</b>	<b>9. AGE last birthday</b> <b>63</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>Days</b>	<b>IF UNDER 24 HRS</b> Hours <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Railroad</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Albert Crummitt</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Creager</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>NO</b> (If Yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>705-12-3741</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>450 West South Street, Mrs. Mabel M. Crummitt, Frederick, Md.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. IMMEDIATE CAUSE (A)</b> <b>4X</b>				<b>18a. MEDICAL CERTIFICATION</b> <b>Bacteremia</b>		<b>3 days</b>	
<b>2. ANTECEDENT CAUSE(S) DUE TO</b>				<b>18b. MEDICAL CERTIFICATION</b> <b>Carcinoma of rectum</b>			
<b>3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>18c. MEDICAL CERTIFICATION</b> <b>Sigmoid - perforated</b>		<b>year +</b>	
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 3, 1955, to Dec 15, 1955, that I last saw the deceased alive on Dec 14, 1955, and that death occurred at 3:45 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>B. C. Thomas</b> M.D.				<b>ADDRESS (Street, city, town, state)</b> <b>Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>12/16/1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Dec. 19, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Frederick Memorial Park</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Frederick, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Elizabeth B. Hach</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			



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## INSTRUCTIONS

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VS A15C 1-55

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11933

## 11953 CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Brunswick</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Brunswick</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>516 West Potomac</b>		STREET ADDRESS (If rural give location) <b>516 West Potomac</b>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Bessie Broome Danner</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12 22 55</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Widowed</b>	8. DATE OF BIRTH <b>8-23-1876</b>
9. AGE last birthday <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Williams</b>		14. MOTHER'S MAIDEN NAME <b>Virginia A. Denton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT & ADDRESS <b>Doras Robertson, Brunswick, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <b>Seriniton</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-22-55</b> to <b>12-22-55</b> , that I last saw the deceased alive on <b>12-22-55</b> , and that death occurred at <b>11:45</b> M. from the causes and on the date stated above. SIGNATURE <b>[Signature]</b> ADDRESS (Street, city, town, state) <b>Brunswick, Md.</b> DATE SIGNED <b>12-23-55</b> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>12-26-55</b>	NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>	LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>
24. REC'D BY REGISTRAR DATE <b>1-3-56</b>	REGISTRAR'S SIGNATURE <b>Eugenia H. Bush</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C.H. Feete and Bro. Brunswick, Md.</b>	

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BUREAU V. E.



11958 **CERTIFICATE OF DEATH**

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Frederick-Rural</u>		<u>14</u> Days		TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick County Chronic Hospital</u>				STREET ADDRESS (If rural give location) <u>616 North Market Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>RESTA</u>		(Middle) <u>LEVI</u>		(Last) <u>DELAUTER</u>		<u>December 31, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>August 22, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George W. Delauter</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Hoover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-6298</u>		17. INFORMANT & ADDRESS <u>Mrs. Alfred F. Brashear, 53 Taney Apts. Frederick, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>16. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Cerebral occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
<b>22. I hereby certify that I attended the deceased from <u>Sept 21, 1955</u>, to <u>Dec 31, 1955</u>, that I last saw the deceased alive on <u>Dec 31, 1955</u>, and that death occurred at <u>11:35 PM</u>, from the causes and on the date stated above.</b>							
SIGNATURE <u>B. Thomas</u>		M. D.		ADDRESS (Street, city, town, state) <u>Frederick, Maryland</u>		DATE SIGNED <u>1/2/1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR <u>3 Jan. 1956</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11933 CERTIFICATE OF DEATH

11935

Reg. Dist. No. 13

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> STREET ADDRESS (If rural give location) <u>7 West All Saints Street</u>	
3. NAME OF DECEASED (First) <u>YVONNE</u> (Middle) <u>DISNEY</u> (Last) <u>DISNEY</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 22, 1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Paul Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Mae Disney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Dorothy Disney</u> <u>T.W. ALL</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 7725 IMMEDIATE CAUSE (A) <u>Sclerosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Presenility</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <u>12-22-1955</u> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-22-1955</u> to <u>12-26-1955</u> , that I last saw the deceased alive on <u>12-26-1955</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Frank J. Hearn</u> M.D.		ADDRESS (Street, city, town, state) <u>220 N. Market St.</u> DATE SIGNED <u>12-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-28-55</u> NAME OF CEMETERY OR CREMATORY <u>BARTONSVILLE</u> LOCATION (City, town, or county) (State) <u>BARTONSVILLE-Md.</u>	
24. REC'D BY REGISTRAR DATE <u>28 Dec 1955</u> REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. E. Hicks III</u> ADDRESS <u>Fred. Md.</u>	

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## 11959 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
<del>CITY</del> (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		<del>CITY</del> (If outside corporate limits, write OR and give nearest town)		RURAL and give nearest town)	
TOWN Urbana		65 yrs.		TOWN Urbana -- 7 miles S. of Frederick		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Mary Rosalia Dudderar				Dec. 28 19 55			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: Jan. 4-1868	
9. AGE last birthday: 87 yrs.		10. USUAL OCCUPATION, Give kind of work done during most of working life, even if retired): Housewife		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John C. Kidd				14. MOTHER'S MAIDEN NAME: Ann Howard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Dorothy D. Hull (daughter) Urbana-Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) Congestive failure + uremia						10 days	
Antecedent causes (s) (b) Arterio-sclerotic heart dis.						6 yrs.	
(c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. Auricular fibrillation						2 wks	
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
PLACE (Home, farm, factory, street, office bldg., etc.)				(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 19 51, to 28 Dec 19 55, that I last saw the deceased alive on 27 Dec 19 55, and that death occurred at 4 A.M. from the causes and on the date stated above.							
SIGNATURE Charles H. Conley, Jr. M.D.				DATE SIGNED 12/29/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial				NAME OF CEMETERY OR CREMATORY Frederick, Maryland			
DATE THEREOF 12-30-1955				LOCATION (City, town, or county) (State) Frederick- Maryland			
DATE REC'D BY LOCAL REGISTRAR Dec. 30-1955				24. FUNERAL DIRECTOR C. E. Cline & Son- Frederick- Md.			
REGISTRAR'S SIGNATURE Elizabeth B. Heck				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. W. H. L.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11960

## CERTIFICATE OF DEATH

11937

Reg. Dist. No. 131

Item 9, Film G190 12-23-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick - Rural		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montevue County Home				STREET ADDRESS (If rural give location) Montevue County Home			
3. NAME OF DECEASED: (First) JOSEPH (Middle) (Last) ELDRIDGE		4. DATE OF DEATH: December 19 1955		5. SEX: Male		6. COLOR OR RACE: Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: Unknown		9. AGE last birthday: Approx. 80 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Unknown		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Mat Burras (Eldridge)				14. MOTHER'S MAIDEN NAME: Maggie Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Montevue County Home - Frederick, Maryland			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) 442x						3410	
Antecedent causes (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) Chronic nephritis						3410	
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953, to 1955, that I last saw the deceased alive on 7, 1955, and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Dec. 20, 1955		Anatomical Board		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
20 Dec. 1955		Elizabeth B. Heck		C. E. Cline & Son - Frederick, Maryland			



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## 11961 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)	
X TOWN Frederick-Rural RD#3		Years		TOWN Frederick-Rural RD#3		Years	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near Yellow Springs				STREET ADDRESS (If rural give location) Near Yellow Springs			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) URIAH		(Middle) VERNON		(Last) FEAGA		December 17, 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
Male	White	Widowed	20 July 1870	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farm Owner		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Julia A. R. McLane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		408 Culler Ave., Russell S. Feaga, Frederick, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				400.1 IMMEDIATE CAUSE (A) Coronary Thrombosis			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				5 yrs.			
STATING UNDERLYING CAUSE LAST, DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 10, 1953, to Dec 13, 1955, that I last saw the deceased alive on Jan 15, 1955, and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
B. H. H. M. M. D. Frederick, Maryland				19 Dec 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		20 Dec 1955		Mount Olivet Cemetery		Frederick, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 19-Dec-1955		Elizabeth S. Heck		M. R. Etchison & Son, Frederick, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M



11939

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

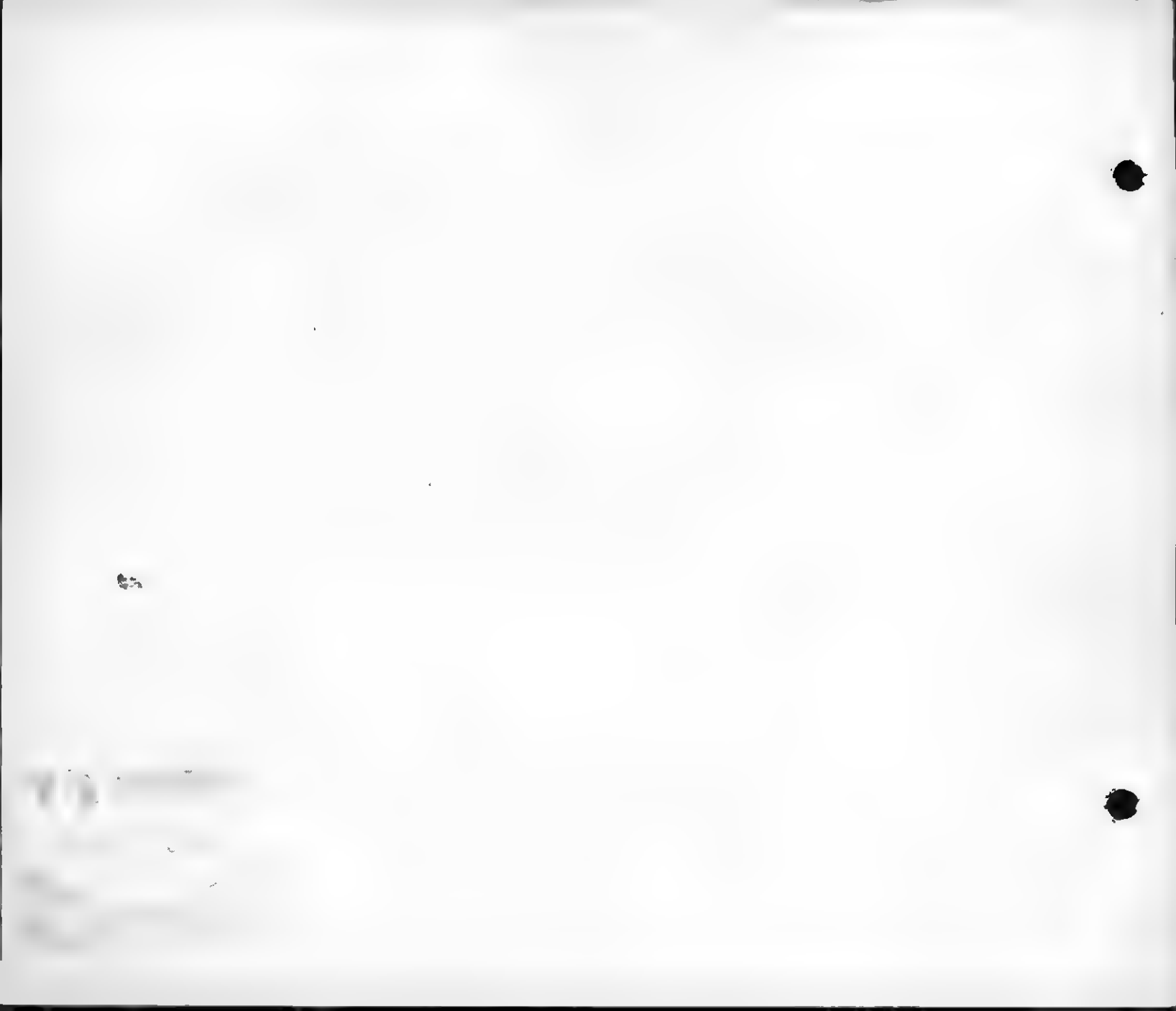
## 11934 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN Frederick</u>	LENGTH OF STAY (in this place) <u>5 Minutes</u>	If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Lewistown Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Frederick Memorial</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Zacharias</u>	(Middle) <u>Ursinius</u>	(Last) <u>Fior</u>	OF DEATH: <u>Dec. 14</u> 19 <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug 24 - 1876</u>
9. AGE last birthday <u>79</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Thurmont Fredk Co Md</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Thurmont Fredk Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Martin David Fior</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Heaser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>George M. Fior, Thurmont Md R.O.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) <u>Acute Pulmonary Edema</u>		<u>2 hrs.</u>	
IMMEDIATE CAUSE DUE TO			
(B) <u>Arteriosclerotic Heart Disease</u>		<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>6</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>12/14</u> , 19 <u>55</u> , to <u>12/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>55</u> , and that death occurred at <u>10:45</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>Henry V. Chase M.D.</u>		DATE SIGNED <u>12/14/55</u>	
ADDRESS <u>M.D. F.S. Church St Frederick</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 17, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cem</u>		LOCATION (City, town, or county) <u>Thurmont Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>16 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hersh</u>	
24. FUNERAL DIRECTOR <u>M.L. Creager</u>		ADDRESS <u>Thurmont MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G190 12-23-55 ams

11940

11935

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 8 West Sixth Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) NETTIE SYRENA FISHER				4. DATE OF DEATH (Month) (Day) (Year) December 16, 1955			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1 July 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Mahammitt				14. MOTHER'S MAIDEN NAME Carrie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS 8 W. 6th St., Harry W. Fisher, Frederick, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) PORTAL CIRRHOSIS OF LIVER						YRS.	
2. ANTECEDENT CAUSE(S) DUE TO CHRONIC ALCOHOLISM						7 YRS.	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO Miliary Tuberculosis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <del>XXXXXXXXXXXXXXXXXXXX</del>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 Nov 1955, to 16 Dec 1955, that I last saw the deceased alive on 16 Dec 1955, and that death occurred at 6:15 A.M. from the causes and on the date stated above.							
SIGNATURE Thomas E. Stone M.D.				DATE SIGNED 4 W 3rd St 16 Dec 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 19 Dec 1955		NAME OF CEMETERY OR CREMATORY Silver Hill Cemetery		LOCATION (City, town, or county) (State) Frederick County Maryland	
24. REC'D BY REGISTRAR DATE 19 Dec. 1955		REGISTRAR'S SIGNATURE Elizabeth L. Hark		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland			

DEC

RECEIVED



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AT5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11941

## 11962 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Libertytown		Years		TOWN Libertytown		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street				STREET ADDRESS (If rural give location) Main Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Carlton Elsworth Fogle				Dec. 4 1955			
5 SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	S	May 12, 1933	72	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Drick Layer		Own Business		Frederick County		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John H. Fogle				Ruth Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		220-5-6268		Benjamin Fogle, Libertytown Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 minute	
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis							
ANTECEDENT CAUSE(S) DUE TO						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 18d, 1954, to 4 Dec, 1955, that I last saw the deceased alive on 3 Dec, 1955, and that death occurred at 6:30 PM, from the causes and on the date stated above.							
SIGNATURE James S. Stoner, Jr. M.D.				ADDRESS (Street, city, town, state) DATE SIGNED 5 Dec 55			
23. BURIAL (CREMATION, REMOVAL (SPECIFY))		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 7, 55		Linganore		Unionville Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 7 Dec 1955		Elizabeth B. Heck		D. D. Hartzler & Sons		Libertytown	

MD



11936

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN FREDERICK</u>		LENGTH OF STAY (in this place) <u>- 26 - da</u>		OR TOWN <u>THURMONT</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 FREDERICK MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>WEST MAIN STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARTIN E. FOREMAN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>DECEMBER 7 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>JANUARY 14, 1864</u>	9. AGE last birthday: <u>91</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Mln.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Business</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Foreman</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Sefton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>William Foreman Thurmont, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Anteriosclerotic Heart Disease</u>						15 yrs +	
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Benign prostatic hypertrophy, cellulitis, right shoulder</u>						5 yrs. +, 6 days.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-11, 1955</u> to <u>12-7, 1955</u> that I last saw the deceased alive on <u>12-7, 1955</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>		ADDRESS <u>M. D. 4 E. Church St</u>		DATE SIGNED <u>12/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>U.B. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Thurmont, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 9 - 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth H. Heck</u>		24. FUNERAL DIRECTOR <u>M.L. Creager and Son</u>		ADDRESS <u>Thurmont, Md.</u>	

MARGIN RESERVED FOR FILING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
DEC 12 1955  
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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11937

## CERTIFICATE OF DEATH

11943

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Several Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>65 South Market Street</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) (Also Known As <b>Stella M. Freed</b> ) <b>ESTELLA MARY JANE FREED</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 17, 1955</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Divorced</b>	<b>8. DATE OF BIRTH</b> <b>10 April 1890</b>	<b>9. AGE last birthday</b> <b>65</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House-work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward S. Earnest</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Clara E. Poole</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>65 S. Market St., Frank E. Harley, Frederick, Md.</b>			
<b>18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>I. IMMEDIATE CAUSE (A)</b> <b>Chronic Myocarditis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs</b>			
<b>II. ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Spasmodic asthma</b>				<b>5 yrs</b>			
<b>III. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Chronic Myocarditis</b>				<b>5 yrs</b>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>C</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1955 to 1955, that I last saw the deceased alive on 1955, and that death occurred at 4 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Frederick</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M. D. Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>19 Dec 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>21 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Beaver Dam Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Near Johnsville, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE 20 Dec, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elizabeth B. Hech</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			

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7. 3. 1977

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11963

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Middletown</i>		<i>10 years</i>		TOWN <i>Middletown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Sarah E. Gaver</i>				<i>12 18 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	10. UNDER 1 YEAR	11. UNDER 24 HRS.	
<i>Female</i>	<i>white</i>	<i>widow</i>	<i>11-1-1882</i>	<i>73 yrs.</i>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>housewife</i>				<i>own home</i>		<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Henry L. Brandenburg</i>				<i>Louisa C. Grassnick</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>				<i>none</i>		<i>Everett H. Gaver, Middletown, Md.</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A)	<i>Coronary occlusion</i>			<i>suddenly</i>
ANTECEDENT CAUSE (B)			(B)	<i>Hypertension + Arterio-sclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(C)	<i>(Enlarged heart.)</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Cerebral Hemorrhage Aug 1955</i>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 15, 1955</i> to <i>Dec 18, 1955</i> that I last saw the deceased alive on <i>Dec 16, 1955</i> , and that death occurred at <i>7:10 AM</i> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<i>J. E. Harp</i>				<i>Middletown</i>		<i>12-19-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-20-1955</i>		<i>Lutheran Cemetery</i>		<i>Middletown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Dec 20, 1955</i>		<i>Elizabeth L. Heck</i>		<i>Blackhill Co.</i>		<i>Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1965

RECEIVED



11964

## CERTIFICATE OF DEATH

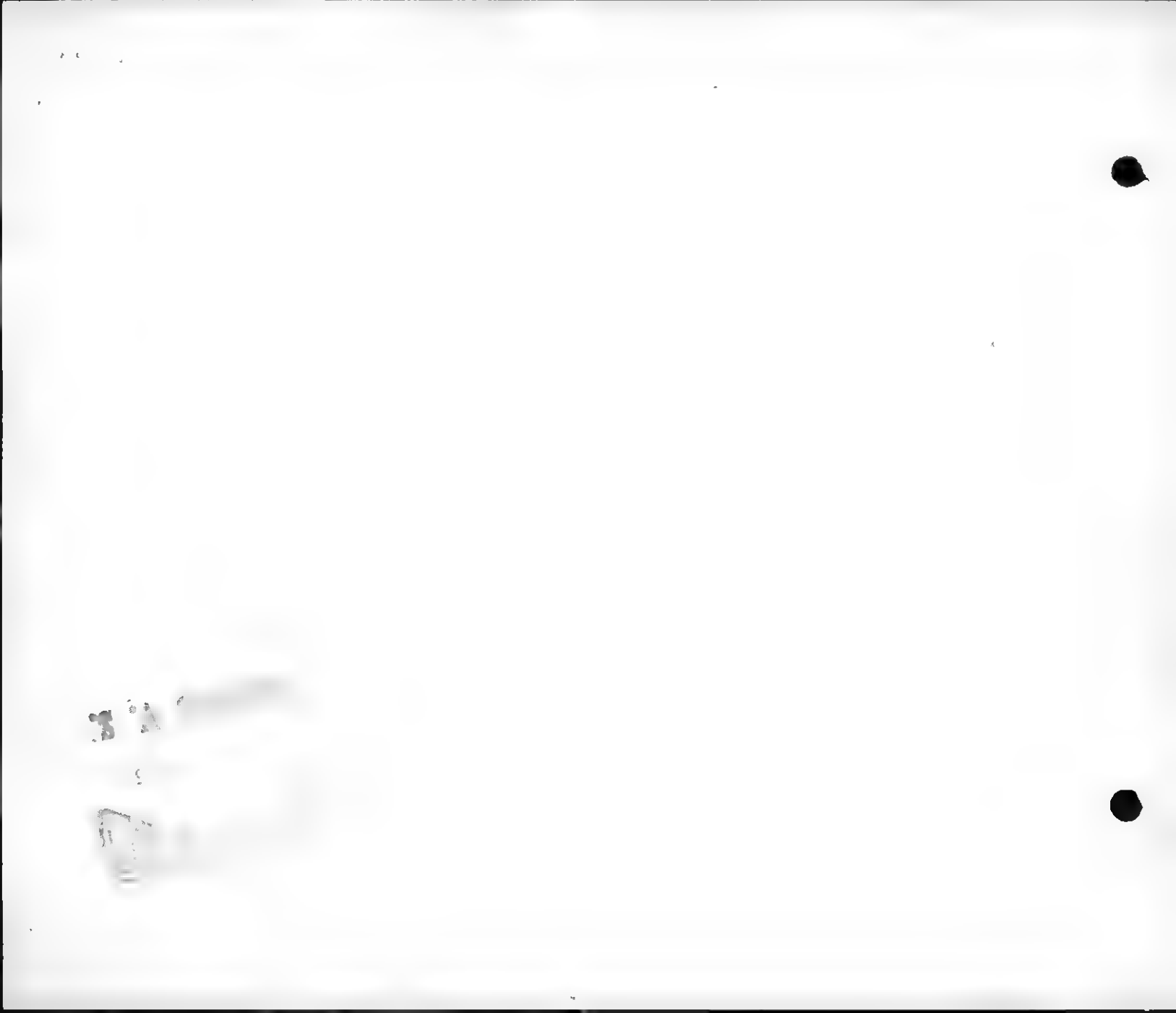
Reg. Dist. No.

11345

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> STATE <u>Md</u> COUNTY <u>Frederick</u> <small>(If outside corporate limits, write RURAL and give nearest town)</small> OR <u>Walker</u> TOWN <u>Walker</u> STREET ADDRESS <u>Frederick St.</u> <small>(If rural give location)</small>	COUNTY <u>Frederick</u> STATE <u>Md</u> COUNTY <u>Frederick</u> <small>(If outside corporate limits, write RURAL and give nearest town)</small> OR <u>Walker</u> TOWN <u>Walker</u> STREET ADDRESS <u>Frederick St.</u> <small>(If rural give location)</small>		
3. NAME OF DECEASED: (Type or Print) <u>CHARLES FRANKLIN GRISSINGER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 4</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug 13 1868</u>
9. AGE last birthday: <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Butcher</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jacob Grissinger</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mrs Minnie R. Grissinger, Walker, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive myocardial failure</u>		<u>4 years</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic CVD</u>		<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Inanition</u>		<u>6 months</u>	
19A. DATE OF OPERATION: <u>11 Nov., 1948</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11 Nov., 1948</u> , to <u>4 Dec., 1955</u> , that I last saw the deceased alive on <u>4 Dec., 1955</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James S. Starnes</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) <u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>E. C. Barton</u>	
24. FUNERAL DIRECTOR <u>W. C. Barton</u>		ADDRESS <u>Walker, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11938

## CERTIFICATE OF DEATH

11946

Reg. Dist. No. 131

Item 9, Film G190 1-3-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>3 days</u>		OR (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (if rural give location) <u>Main St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Florence M. Gilbert</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 14</u> 19 <u>55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH: <u>Dec 10 - 1878</u>	9. AGE last birthday: <u>77 11/4</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>John J. Blingan</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Wishtmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Earl Myers - Taneytown Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Small intestinal obstruction due to gallstone</u>						3 days	
ANTECEDENT CAUSE (B) <u>gallstone</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>13 December '55</u>				19B. MAJOR FINDINGS OF OPERATION: <u>intestinal obstruction due to gallstone. carcinoma of colon</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE (Home, farm, factory, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11 Dec</u> , 19 <u>55</u> , to <u>14 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>15 Dec</u> , 19 <u>55</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. R. H. Pilgram</u>				ADDRESS <u>Frederick, Md.</u>		DATE SIGNED <u>14 Dec '55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>		LOCATION (City, town, or county) (State) <u>Uniontown.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 15-1955</u>		REGISTRAR'S SIGNATURE <u>Edmund H. H. H.</u>		24. FUNERAL DIRECTOR <u>W. H. Hartley &amp; Sons</u>		ADDRESS <u>Union Bridge</u>	

1994

7-270

• 2 •

MARYLAND STATE DEPARTMENT OF HEALTH  
11939 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

11947

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Fredrick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Fred.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fredrick Memorial Hospital</u>		STREET ADDRESS <u>615 East N.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Alice</u> (Middle) <u>Margaret</u> (Last) <u>Giles</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Widowed</u>	8. DATE OF BIRTH <u>9-3-1899</u>
9. AGE last birthday <u>56</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Mln. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hom.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William C. Monroe</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>  </u>	
17. INFORMANT AND ADDRESS <u>Lena Mangum, Washington D.C.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>8:30 Fractured Skull</u>		<u>1 hour</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) <u>  </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>  </u>		19b. MAJOR FINDINGS OF OPERATION <u>  </u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> (CITY OR TOWN) <u>Brunswick</u> (COUNTY) <u>Fredrick</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12</u> <u>17</u> <u>55</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Auto-hit &amp; ejection through way</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>B. Thomas M.D. Deputy Medical Examiner</u>		DATE SIGNED <u>Dec 17-55</u>	
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		DATE THEREOF <u>12-20-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mountain</u>		LOCATION (City, town, or county) <u>Brickell Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>20 Dec. 1955</u> <u>Elizabeth B. Heck</u>		24. FUNERAL DIRECTOR <u>C. H. Felt</u> ADDRESS <u>Brickell Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUNNARD V. S.

DEC 1953

RECEIVED

11965

## CERTIFICATE OF DEATH

11948

Reg. Dist. No. 131

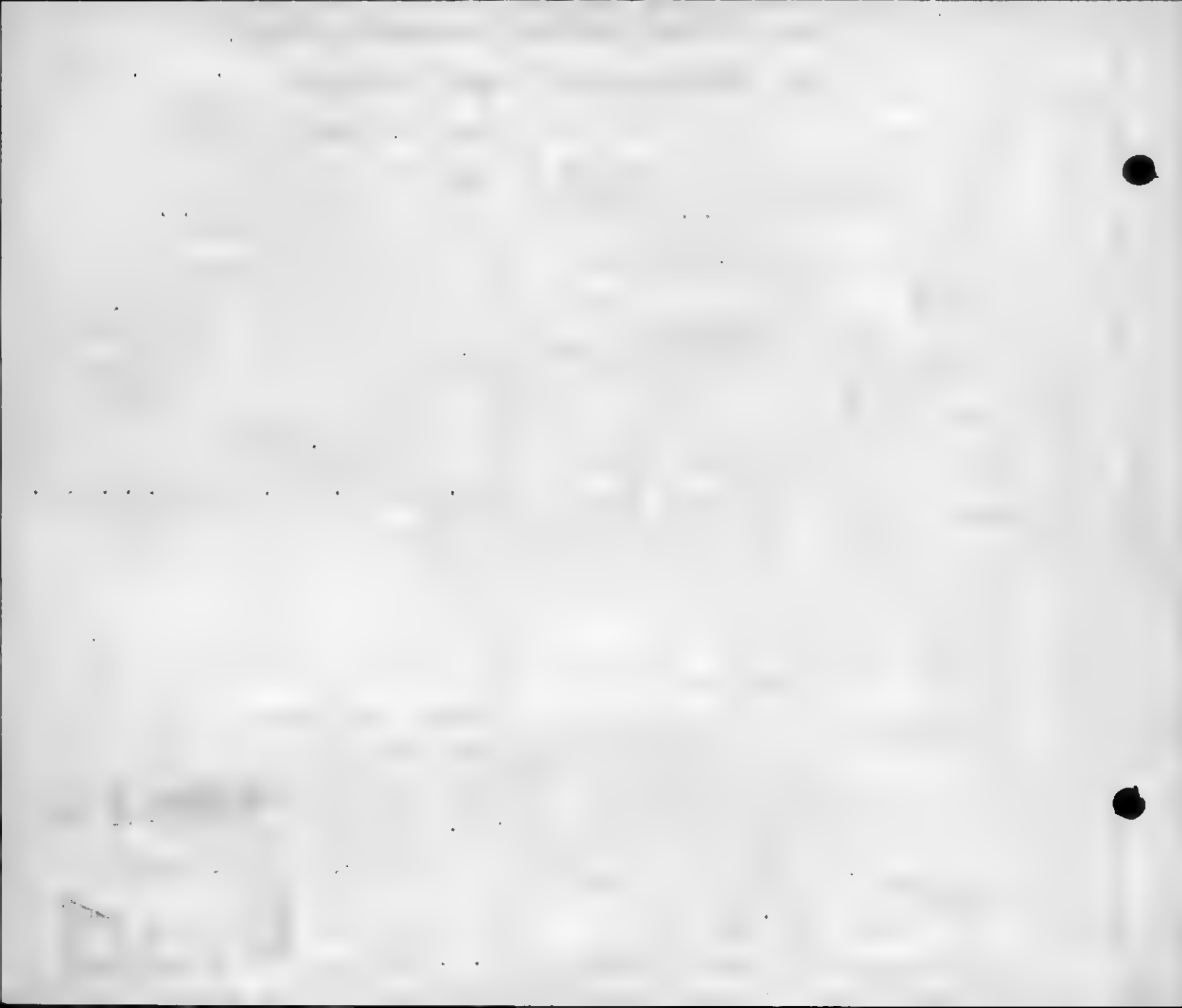
INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural-R.D.#3</u>		LENGTH OF STAY (in this place) <u>3</u> Years		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural-R.D.#3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Three Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Yellow Springs</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CARRIE MAY HAHN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 26, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 8, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Buckey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Nusbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Maurice N. Hahn, Frederick, R.D.#3, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage, due to</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>						<u>10+ years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>						<u>10+ years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>A.S. heart disease w/auricular Fibrillation</u>						<u>1949</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APR 14 DEC 1955</u> to <u>26 DEC 1955</u> , that I last saw the deceased alive on <u>14 DEC 1955</u> and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Corley, Jr.</u>				ADDRESS (Street, city, town, state) <u>Frederick, Maryland</u>		DATE SIGNED <u>12/28/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>28 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hesk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	





11949

Reg. Dist. No.. 3..1

11965

1. PLACE OF DEATH- COUNTY <u>Fredrick</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Fredrick</u>	
3. (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Centerville</u>		LENGTH OF STAY (in this place)		4. (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Centerville</u> STREET ADDRESS <u>Fredrick Rd #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.I</u>					
5. NAME OF DECEASED (First) <u>Edna</u>		(Middle) <u>mae</u>		(Last) <u>Hallman</u>	
6. SEX <u>Female</u>		7. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>Oct 1-1885</u>	
9. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		10. AGE last birthday <u>70</u> yrs.		11. DATE OF DEATH <u>December 23</u> 19 <u>53</u>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
15. FATHER'S NAME <u>Unknown</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>		17. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY No. <u>—</u>		20. INFORMANT AND ADDRESS <u>Walter S. Sander, Centerville</u>	
21. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>Cerebral Thrombosis</u>					
Antecedent cause(s) (b) <u>Arteriosclerosis</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
22. DATE OF OPERATION		23. MAJOR FINDINGS OF OPERATION		24. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
25. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY		27. (CITY OR TOWN) (COUNTY) (STATE)	
28. TIME (Month) (Day) (Year) (Hour) OF INJURY		29. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
32. SIGNATURE <u>Walter S. Sander, M.D., Medical Examiner</u>		33. ADDRESS <u>Fredrick, Md.</u>		34. DATE SIGNED <u>Dec 28-53</u>	
35. BURIAL, CREMATION REMOVAL, (Specify)		36. DATE THEREOF <u>1-2-56</u>		37. NAME OF CEMETERY OR CREMATORY <u>Ebernezzer</u>	
38. LOCATION (City, town, or county) (State) <u>Centerville-Fred. Co. Md.</u>		39. DATE REC'D BY LOCAL REG. <u>30 Dec-1953</u>		40. REGISTRAR'S SIGNATURE <u>Elisabeth B. Heck</u>	
41. FUNERAL DIRECTOR <u>Charles E. Hicks</u>		42. ADDRESS <u>Fred. Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

v.s. A15A

U.S. AIR FORCE

AN 2 1966

RECEIVED

11950

## MARYLAND STATE DEPARTMENT OF HEALTH

11967

## CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Frederick County</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick County Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Middleburg</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Carric</u> (First) <u>E</u> (Middle) <u>Harbough</u> (Last)	4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>1st</u> (Year) <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11/11/1860</u>
9. AGE last birthday <u>95</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Primary school teacher</u>	11. BIRTHPLACE (State or foreign country) <u>Woodsboro, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Samuel Harbough</u>	14. MOTHER'S MAIDEN NAME <u>Mary Anders</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT AND ADDRESS <u>Mrs. Wm. C. Fuss, Taneytown, Maryland</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.0</u> (a) <u>Intermyocardial vessel disease</u>			<u>6 mo.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Congestive Heart Failure</u>			
(c) <u>Arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>A. A. Pearce M.D.</u>		DATE SIGNED <u>Frederick Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/14/55</u>	NAME OF CEMETERY OR CREMATORY <u>Middleburg Cemetery</u>	LOCATION (City, town, or county) (State) <u>Middleburg, Maryland</u>
DATE REC'D BY LOCAL REG. <u>1 Dec. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	24. FUNERAL DIRECTOR <u>W. C. Fuss &amp; Son, Taneytown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEC

REGION 50

BOOK 11

11951

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11940

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	OR (If outside corporate limits, write RURAL and give nearest town)	
<u>11 TOWN Frederick</u>	<u>1 day</u>	OR TOWN <u>Mt. Airy</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>69 Frederick Memorial</u>	<u>06x-2</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Lottie E. Harrison</u>		OF DEATH: <u>12</u> <u>11</u> <u>1955</u>	
5. SEX: <u>E</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>8-29-1867</u>
9. AGE last birthday: <u>88</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Benjamin Hood</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Albert Harrison, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Lobar Pneumonia right lobe</u>		<u>4-5 days</u>	
ANTECEDENT CAUSE (B) <u>and middle lobes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Anterior lobe, generalized</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>? years</u>	
19A. DATE OF OPERATION: <u>12/10</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/10</u> , 19 <u>55</u> , to <u>12/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> P, from the causes and on the date stated above.			
SIGNATURE <u>Henry V. Chase</u>		ADDRESS <u>M. D. 4 E. Church St. Fred.</u>	DATE SIGNED <u>12/11/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>12-14-1955</u>	<u>Prospect</u>	<u>Frederick Co., Maryland</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>13 Dec. 1955</u>	<u>Elizabeth S. Webb</u>	<u>C. M. Waltz, Winfield, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE

3 16 1955

RECEIVED

## 11968 CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rural Knoxville		30 yrs.		TOWN Rural Knoxville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Howard Marvin Jones				I2 2I 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	5-2I-1874	8I yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if real estate, Ins.)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Office			Office	Virginia MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Leouis R. Jones				ELIZABETH ANDERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, of unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
No					Alfred Jones, Falls Church, Va.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Cerebral Thrombosis			
ANTECEDENT CAUSE(S) DUE TO (B)				Generalized Arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Diabetes Semblity			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				12 days			
				10 yrs			
				15 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954, to 12/21, 1955, that I last saw the deceased alive on 12/20, 1955, and that death occurred at M, from the causes and on the date stated above.							
C. L. Brice M.D.				ADDRESS (Street, city, town, state) DATE SIGNED 12/23/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-24-55		Park Heights		Brunswick, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-8-56		Eugenia H. Bucke		C.H. Feete and Bro. Brunswick, Md			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 70M

BUREAU V. S.

JAN 5 1956

RECEIVED



## 11969 CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Prince Georges</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cullen</b>		LENGTH OF STAY (in this place) <b>926 days.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>Washington Boulevard</b>			
3. NAME OF DECEASED: (First) <b>Luther</b> (Middle) <b>E.</b> (Last) <b>Leanhart</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>December 23, 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Oct. 4, 1899</b>	9. AGE last birthday <b>56</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Truck driver</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Truck Driver</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Eugene Leanhart</b>				14. MOTHER'S MAIDEN NAME: <b>Laura Studebaker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT & ADDRESS: <b>Luther E. Leanhart, Laurel, Maryland.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <b>Pulmonary Tuberculosis</b>				<b>3 years.</b>	
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 10, 1953</b> , to <b>Dec. 23, 19 55</b> that I last saw the deceased alive on <b>Dec. 23, 1955</b> , and that death occurred at <b>7:40 p.m.</b> from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		M. D. <b>Cullen, Maryland</b>		DATE SIGNED <b>December 27, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		DATE THEREOF <b>12-29-55</b>		NAME OF CEMETERY OR CREMATORY <b>Anatomy Board, U. of Md. Medical School</b>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <b>12/27/55</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR <b>M. L. Creager &amp; Son, Thurmont, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC

1911

11970

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>FREDERICK</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>YELLOW SPRINGS</u>	LENGTH OF STAY (in this place) <u>Lifelong</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Yellow Springs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>RURAL</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>ANNIE</u>	(Middle) <u>MAY</u>	(Last) <u>MARTZ</u>	(Month) <u>Dec.</u> (Day) <u>5</u> (Year) <u>19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 6, 1870</u>
9. AGE last birthday: <u>85</u> yrs.		10. AGE last birthday: If UNDER 1 YEAR, Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home Making</u>	
11. BIRTHPLACE (State or foreign country): <u>Frederick, County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob Zimmerman</u>		14. MOTHER'S MAIDEN NAME: <u>Ann Rebecca Ransburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Son, Louis J. Martz, Yellow Springs Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <u>422.0 Congestive Heart failure</u>		<u>1 Day</u>	
Antecedent causes (s) (b) <u>Arteriosclerotic Heart Disease</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>12-7-55</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-5-55</u> , 19 <u>55</u> , to <u>12-5-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-5-55</u> , 19 <u>55</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. J. Fisher</u>		DATE SIGNED <u>6 Dec 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12-7-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Herb</u>	
24. FUNERAL DIRECTOR <u>Robert E. Dailey</u>		ADDRESS <u>FREDERICK MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S.

11941

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

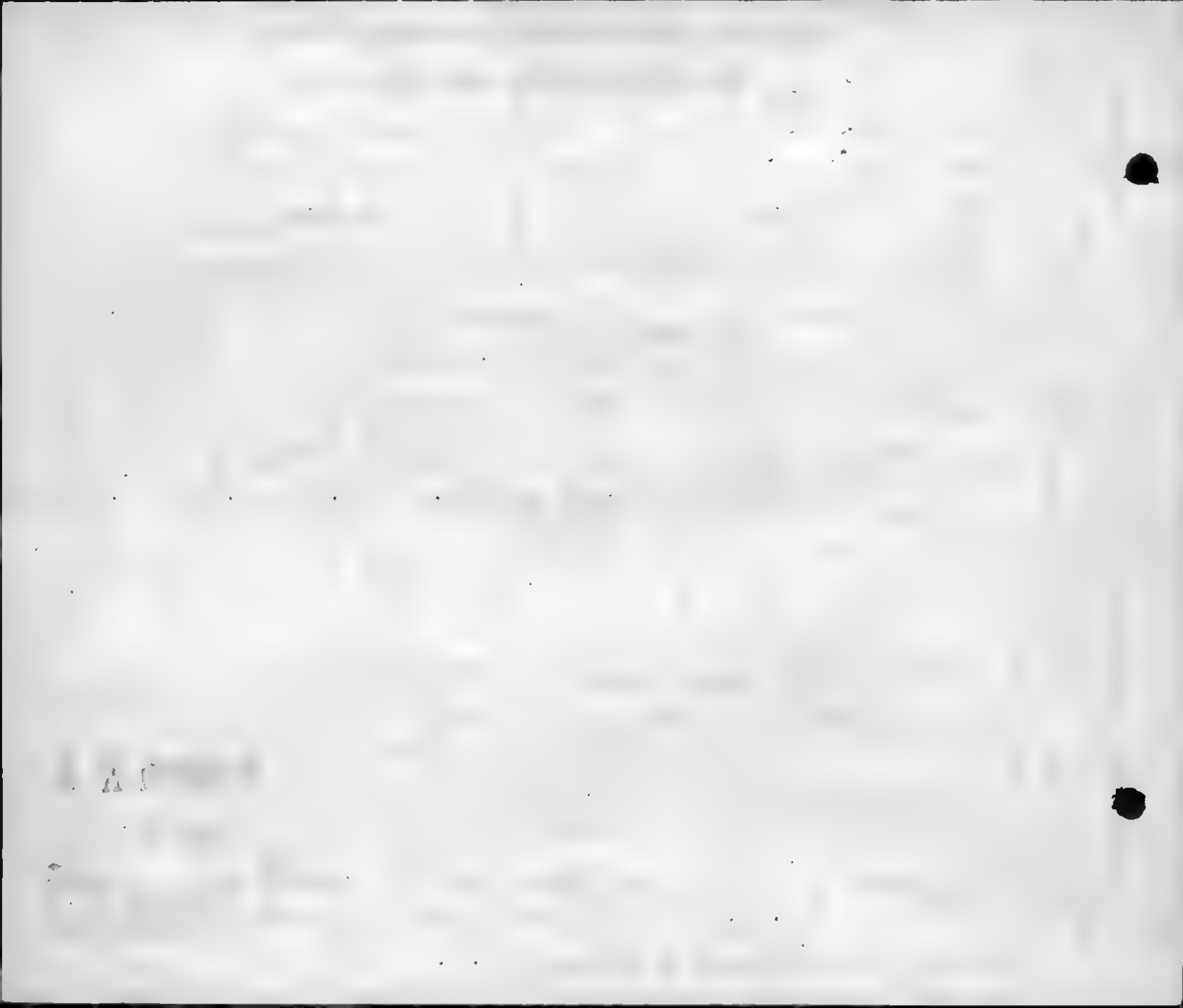
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Frederick</u>		Years		TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>507 Lee Place</u>			
3. NAME OF DECEASED (Type of Print)				4. DATE OF DEATH			
(First) <u>AUSTIN</u> (Middle) <u>HENRY</u> (Last) <u>McDEVITT</u>				(Month) (Day) (Year) <u>December 25, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 26, 1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Foreman</u>		<u>Everedy Company</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Charles McDevitt</u>				14. MOTHER'S MAIDEN NAME <u>Nora Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>507 Lee Place, Mrs. Grace C. McDevitt, Frederick, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>4 weeks</u>			
DUE TO							
DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5:00 P.</u> , 19 <u>55</u> , to <u>5:00 P.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5:00 P.</u> , 19 <u>55</u> , and that death occurred at <u>5:00 P.</u> M. from the causes and on the date stated above.		SIGNATURE <u>Frederick, Maryland</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12/28/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 29, 1955</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>28 Dec. 1955</u>		<u>Elizabeth S. Heick</u>		<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11942

## CERTIFICATE OF DEATH

11956

Reg. Dist. No. 131

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN Frederick</u>	LENGTH OF STAY (In this place) <u>4 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Hospital</u>		STREET ADDRESS (If rural give location) <u>121 E 6th St.</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>VIRGINIA</u> <u>Mc MILLAN</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>DEC. 28</u> <u>19 55</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>1-16-1907</u>
<b>9. AGE last birthday</b> <u>48</u> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home Econ.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home Econ.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Robert W. Meredith</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannie A. Rose</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>227-05464</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Robert W. Meredith</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>Congestive Failure</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 Mos</u>	
<b>ANTECEDENT CAUSE(S)</b> (B) <u>Large Anterior Myocardial Infarction</u>		<b>? years</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>of unknown etiology</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Auricular Fibrillation (+ Vent. fibr. (?)</u>		<b>2 Mos</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. HOW DID INJURY OCCUR?</b>	
<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
<b>22. I hereby certify that I attended the deceased from 19 51 to 12/28, 19 55, that I last saw the deceased alive on 12/28, 19 55, and that death occurred at 5:45 P.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>Charles H. Corley</u>		<b>DATE SIGNED</b> <u>12/28/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REGISTRAR'S SIGNATURE</b> <u>Elizabeth H. Heck</u>	
<b>DATE</b> <u>29 Dec. 1955</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frederick, Maryland</u>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

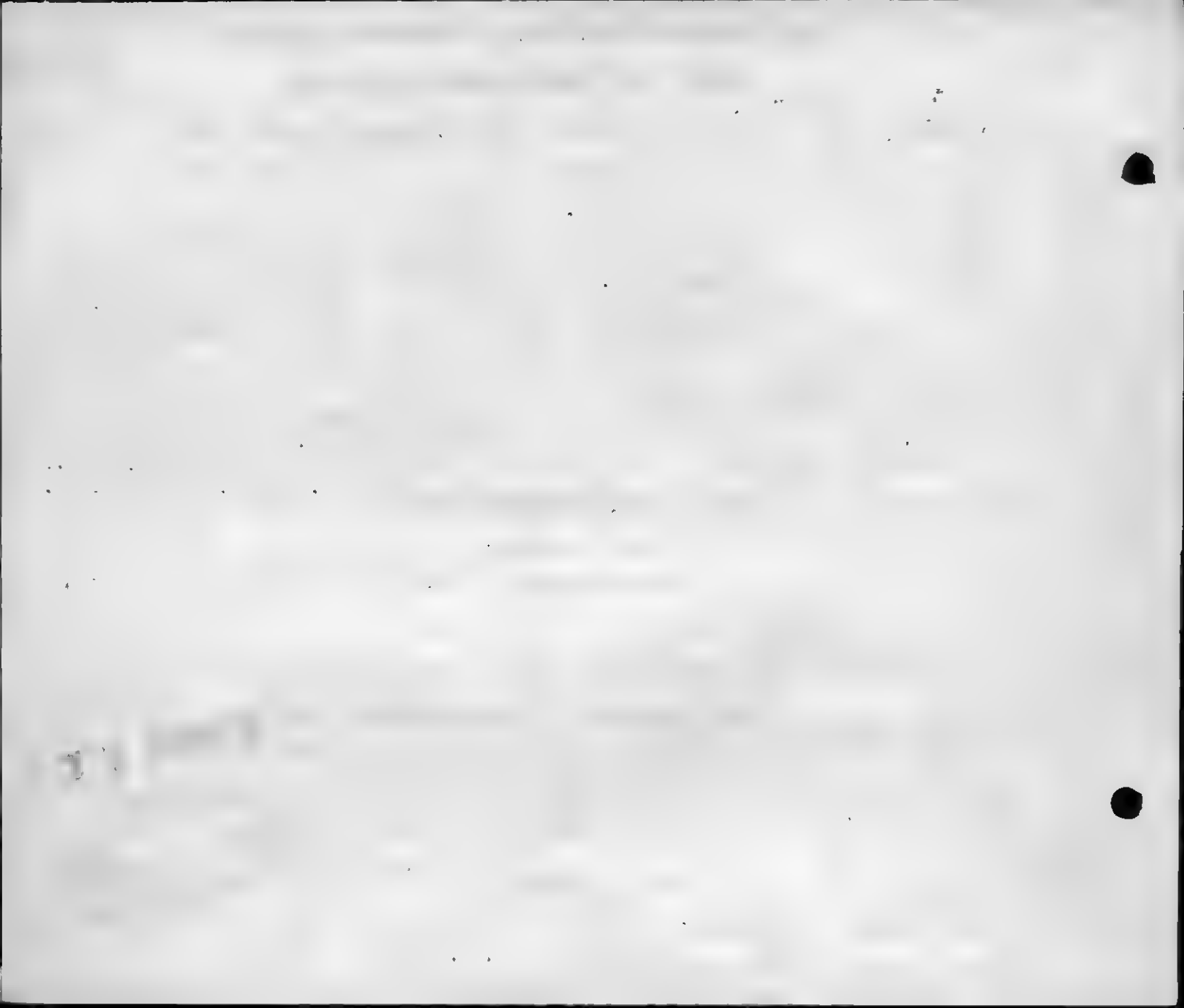
11943

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

11957

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frederick		LENGTH OF STAY (In this place) 44 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 300 Park Avenue			
3. NAME OF DECEASED (Type or Print) (First) BENJAMIN (Middle) FRANKLIN (Last) MILLER				4. DATE OF DEATH (Month) (Day) (Year) December 4, 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 9 Nov 1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Deliveryman		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Miller				14. MOTHER'S MAIDEN NAME Lucretia Longman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS 300 Park Ave., Miss Esther V. Miller, Frederick, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Cerebral hemorrhage						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis - arteriosclerotic heart disease						4 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/1/1955, to 12/4/1955, that I last saw the deceased alive on 12/4/1955, and that death occurred at 2:40 P.M. from the causes and on the date stated above.							
SIGNATURE A. A. Pearce				ADDRESS (Street, city, town, state) Frederick, Maryland		DATE SIGNED 5 Dec 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7 Dec 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Elizabeth G. Zuck		25. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			



## CERTIFICATE OF DEATH

Reg. Dist. No. 131

11971

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Mt. Pleasant		LENGTH OF STAY (in this place) 2 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 210 South Carroll Street			
3. NAME OF DECEASED: (First) Joshua (Middle) Eli (Last) Murphy				4. DATE OF DEATH: Dec. 14 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Oct. 15-1889	
				9. AGE last birthday: 66 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Brakeman		10b. KIND OF BUSINESS OR INDUSTRY: Electric Railway		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Elias Murphy				14. MOTHER'S MAIDEN NAME: Mary Phelps			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Edward L. Cramer-Rt. 1-Mt. Pleasant-Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) Pulmonary Metastases of Carcinoma						11 months	
Antecedent causes (s) (b) Carcinoma of Larynx						8 1/2 years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 14, 1947, to Dec. 14, 1955, that I last saw the deceased alive on Dec. 14, 1955, and that death occurred at 6:10 P.M., from the causes and on the date stated above.							
SIGNATURE S. R. Schoorman M.D.				ADDRESS Frederick Md. DATE SIGNED 12-16-55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 12-17-1955		NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick-Maryland	
DATE REC'D BY LOCAL REGISTRAR 16 Dec. 1955		REGISTRAR'S SIGNATURE Elizabeth G. Hech		24. FUNERAL DIRECTOR C. E. Cline & Son		ADDRESS Frederick-Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*[Faint handwritten notes and stamps are visible at the bottom of the page.]*

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18 Film G190-12-20-55 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11959  
11944 CERTIFICATE OF DEATH Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write and give nearest town) <u>11 Frederick</u>		LENGTH OF STAY (in this place) <u>22 days</u>		If outside corporate limits, write RURAL and give nearest town <u>Detour Rural</u> <u>66X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ernest D. Myers</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>10</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>3/5/1915</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed</u>		9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min. <u>60</u> yrs		11. BIRTHPLACE (State or foreign country): <u>Carroll Co. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>Rufus Myers</u>			
14. MOTHER'S MAIDEN NAME: <u>Mary C. Gouker</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 No</u>			
16. SOCIAL SECURITY NO.: <u>No</u>				17. INFORMANT & ADDRESS: <u>Mrs Bessie Myers</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Adenocarcinoma of the body of the pancreas</u>						<u>1 yr.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/17</u> , 1955, to <u>12/10</u> , 1955, that I last saw the deceased alive on <u>12/10</u> , 1955, and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>		ADDRESS <u>M. D. 4 E. Church St. Fred.</u>		DATE SIGNED <u>12/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Keysville Cem.</u>		LOCATION (City, town, or county) (State) <u>Keysville Carroll Co. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hack</u>		24. FUNERAL DIRECTOR <u>M. L. Creager &amp; Son. Thurmont MD</u>		ADDRESS	

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11972

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <b>Cullen</b>		<b>172 days.</b>		TOWN <b>Baltimore</b> <b>3401-4</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>1634 Aliceanne Street,</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>Roland Francis Nelson</b>				<b>December 9, 19 55</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Widower</b>	<b>December 1, 1900</b>	<b>55</b> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<b>Seaman</b>			<b>Seaman</b>		<b>Maine</b>		<b>U.S.A.</b>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>George Nelson</b>				<b>Celia Reed</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>No</b>				<b>090-14-2871</b>		<b>Roland F. Nelson, 1634 Aliceanne St., Balto. Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis.</b>						<b>10 months.</b>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <b>June 20, 1955</b> , to <b>Dec. 9, 1955</b> , that I last saw the deceased alive on <b>Dec. 9, 1955</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.							
SIGNATURE		<b>W. D. Donaldson</b>		M.D. <b>Cullen, Maryland</b>		DATE SIGNED <b>December 10, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12-12-55</b>		<b>Fort Lincoln</b>		<b>Colmar Manor, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>12/10/55</b>		<b>W. D. Donaldson</b>		<b>DeWitt Donaldson, Laurel, Md.</b>			

MARGIN RESERVED FOR BINNING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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11973

## CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rural - Mt. Airy</i>		<i>13 years</i>		TOWN <i>Rural - Mt. Airy</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Route 1 - (Bartholows)</i>				STREET ADDRESS (If rural, give location) <i>Route 1 - (Bartholows)</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Abram Garfield Poole</i>				OF DEATH: <i>December 7 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>May 29, 1882</i>	<i>73 yrs.</i>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Truckman</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Railroad</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME: <i>William Washington Poole</i>				14. MOTHER'S MAIDEN NAME: <i>Eliza Virginia Hall</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No.</i>				16. SOCIAL SECURITY NO. <i>219-20-0336</i>		17. INFORMANT & ADDRESS: <i>Mrs. Abram G. Poole - Rt. 1 - Mt. Airy.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>420.0</i>		
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>		<i>21 hours</i>
ANTECEDENT CAUSE (B) <i>Arteriosclerotic Heart Disease</i>		<i>several years.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. HOW DID INJURY OCCUR?
	21F. WHILE <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	

22. I hereby certify that I attended the deceased from *May* 1950, to *December* 1955, that I last saw the deceased alive on *December 6, 1955*, and that death occurred at *1:59* A.M., from the causes and on the date stated above.

SIGNATURE <i>W.B. Culwell</i>	ADDRESS <i>Mt. Airy, Md.</i>	DATE SIGNED <i>December 7, 1955</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Dec. 9, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Pleasant Hill</i>
LOCATION (City, town, or county) (State) <i>Monrovia, Fred. Co. Md.</i>	DATE REC'D BY LOCAL REGISTRAR <i>Dec 5 - 1955</i>	REGISTRAR'S SIGNATURE <i>Lucas K. Falconer</i>
FUNERAL DIRECTOR ADDRESS <i>Olin L. Moleworth, Damascus, Md.</i>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11962

## 11945 CERTIFICATE OF DEATH

Reg. Dist. No. 144

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>Several minutes</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Charles Clayton Putman</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 19, 1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>October 31, 1881</u>		<b>9. AGE last birthday</b> <u>74</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Free Contractor</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Creagerstown, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Greenberry Putman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Joy Putman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-18-6849</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Bessie Mort Putman Lewistown, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>427.1 IMMEDIATE CAUSE (A)</b> <u>myocardial failure</u>						<u>6 hrs.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>chronic myocarditis</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)</b> <u>Arteriosclerosis</u>						<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M.</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Dec. 2, 1955</u>, to <u>Dec. 19, 1955</u>, that I last saw the deceased alive on <u>Dec. 18, 1955</u>, and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>M. Franklin Bink</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Thurmont Md.</u>		<b>DATE SIGNED</b> <u>12/20/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/21/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>United Brethern Cem.</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Thurmont, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Blanche D. Eyles</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>M.I. Creager and Son</u>		<b>ADDRESS</b> <u>Thurmont, Md.</u>	

U. S. A.

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11946

## CERTIFICATE OF DEATH

11963

Reg. Dist. No. 131

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>FREDERICK</b>	MARYLAND	STATE <b>MD.</b>	COUNTY <b>FREDERICK</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>FREDERICK</b>	<b>2 yrs.</b>	TOWN <b>FREDERICK</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>FREDERICK MEMORIAL HOSP.</b>		<b>346 PARK AVE</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>JAMES</b> (Middle) <b>A</b> (Last) <b>REID</b>		(Month) <b>DEC</b> (Day) <b>19</b> (Year) <b>1955</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>8-25-53</b>
9. AGE last birthday <b>2</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES R. REID</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE PINNEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <b>Mother.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<b>5 days.</b>	
IMMEDIATE CAUSE (A) <b>BRONCHOPNEUMONIA</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>MUCOVISCIDOSIS</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-12-55</b> to <b>12-19-55</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12-19-55</b> , 19 <b>55</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Dr. J. H. Hearn</b>		ADDRESS (Street, city, town, state) <b>220 N. Market St. Frederick, Md.</b>	
		DATE SIGNED <b>12-19-55</b>	
23. BURIAL, CREMATION, OR OTHER (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Dec. 21, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	LOCATION (City, town, or county) <b>Frederick, Md.</b>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <b>Elizabeth H. Heck</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Williams</b>	ADDRESS <b>FREDERICK, MD.</b>
DATE <b>20 Dec. 1955</b>			

02

3-1-1944

03

1-1-1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

11964

# 11974 CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Adamstown-Rural-R.D.#1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Adamstown-Rural-R.D.#1</u>	
TOWN <u>Adamstown-Rural-R.D.#1</u>		TOWN <u>Adamstown-Rural-R.D.#1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Buckeystown</u>		STREET ADDRESS (If rural, give location) <u>Near Buckeystown</u>	
3. NAME OF DECEASED (First) <u>NETTIE</u> (Middle) <u>LEOTA</u> (Last) <u>REMSBERG</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 12, 1927</u>
9. AGE last birthday <u>28</u> yrs. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Kolb</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Ramsburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Willis D. Remsburg, Adamstown, R.D.#1, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Gun Shot wound of chest</u>		<u>Instantaneous</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>penetrated thru heart</u>			
(c) <u>  </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Near Buckeystown Frederick</u>	(COUNTY) <u>Md</u> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 23-1955</u> <u>30</u> p.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR <u>Gun Shot wound Self-inflicted</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>R. P. Remsburg</u> (Degree or title) <u>Deputy Medical Examiner, Frederick, Maryland</u>		DATE SIGNED <u>12/28/1955</u>	
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	DATE THEREOF <u>Dec. 28, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	LOCATION (City, town, or county) <u>Greagerstown, Maryland</u> (State)
DATE REC'D BY LOCAL REG. <u>21 Dec. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u> ADDRESS	

BUREAU V. S.

DEC 1955

RECEIVED



11975

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Fredrick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Fredrick</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Fredrick - Rural</u>	<u>2 days</u>	TOWN <u>Chesow Bridge Rural</u>	X
HOSPITAL OR INSTITUTION, OR STREET ADDRESS <u>Fredrick County Chronic Hospital</u>		STREET ADDRESS (If rural, give location) <u>Johnsville</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)			
<u>FANNIE BELLE REPP</u>		<u>Dec. 19 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 3 - 1892</u>
9. AGE last birthday: <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clothing mfg.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Repp</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Heron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>215-18-1792</u>	
17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>			
DUE TO			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic VD</u>			
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive VD</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1955</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>April, 1950</u> to <u>19 Dec., 1955</u> , that I last saw the deceased alive on <u>19 Dec., 1955</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James E. Horn</u>		DATE SIGNED <u>19 Dec 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 20/55</u>		REGISTRAR'S SIGNATURE <u>Elizabell E. Heck</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Wolberville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11947

CERTIFICATE OF DEATH

Reg. Dist. No. 11966

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>FREDERICK</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 FREDERICK</u>	LENGTH OF STAY (in this place) <u>0 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 FREDERICK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FREDERICK MEM. HOSP.</u>		STREET ADDRESS (If rural give location) <u>309 MADISON ST.</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>TINA</u>	(Middle) <u>FRANCES</u>	(Last) <u>RIVRERA</u>	OF DEATH: <u>12</u> <u>20</u> <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>NEGRO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12-12-55</u>
9. AGE last birthday		IF UNDER 1 YEAR	
		Months	Days
			Hours
			Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		<u>MD.</u>	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
<u>ROLAND FOREMAN</u>	<u>FAY INEZ RIVRERA</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS:
<u>4</u> (If Yes, give war or dates of service)	<u>-</u>	<u>Mother</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) <u>GASTO-INTESTINAL HEMORRHAGE</u>		
IMMEDIATE CAUSE		
(B) <u>HYPOTHROMBINEMIA</u>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>PREMATURITY</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<u>0</u>		

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-12, 1955, to 12-20, 1955, that I last saw the deceased alive on 12-20, 1955, and that death occurred at 5<sup>35</sup> P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<u>Dr. J. H. H. H.</u>	<u>M. D. 220 N. MARKET ST.</u>	<u>12-20-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>12-22-55</u>	<u>FAIRVIEW</u>
LOCATION (City, town, or county)		(State)
<u>FREDERICK - MD.</u>		

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>22 Dec. 1955</u>	<u>Elizabeth L. Heck</u>	<u>Chas. E. Hicks III</u>	<u>Fred. Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 1 1971

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## CERTIFICATE OF DEATH

11967

131

Reg. Dist. No.

11948

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FREDERICK MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>463 West South Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>BBBY BOY SHANK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 23 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-23-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PAUL SHANK</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET STONEBURNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>FETAL IMMATURITY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-23</u> , 19 <u>55</u> , to <u>12-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>55</u> , and that death occurred at <u>5:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Dad / Fredrick P.</u>				ADDRESS (Street, city, town, state) <u>220 N. Market</u>		DATE SIGNED <u>12-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>27 Dec 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>27 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth L. Hach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Md.</u>		ADDRESS	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

DEC 23 1955

BUREAU V. S.

11968

11976

## CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN Rural Myersville		3 yrs		TOWN Rural Myersville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Route #2				Route #2			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print) JERRY		EUGENE SMITH		Dec. 25		1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	white	single	March 5, 1952	3 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
none		none		Frederick, Md.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Raymond Smith				Mary Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no		none		Raymond Smith, Myersville, Md. Rt. #2			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause				(a) Congenital Heart Disease			
Antecedent causes (s)				(b) (Cerebral Palsy)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				(c)			
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
U							
21. SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Birth, 1952, to Dec 25, 1955, that I last saw the deceased alive on Dec 3, 1955, and that death occurred at 8:00 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
J. H. Bittle				12-26-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 27, 1955		United Brethren		Pleasant Walk, Fred. Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
Dec. 27, 1955		J. H. Bittle		Paul F. Bittle, Myersville, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S.

1910



11949

## CERTIFICATE OF DEATH

11969

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY Frederick MARYLAND  
 CITY (If outside corporate limits, write OR and give nearest town) Frederick  
 RURAL LENGTH OF STAY (If this place) 3 days  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Frederick  
 CITY (If outside corporate limits, write RURAL and give nearest town) Frederick  
 STREET ADDRESS (If rural give location) RFD #6

## 3. NAME OF DECEASED:

(First) Randall (Middle) Earl (Last) Smith  
 (Type or Print)

DATE OF DEATH December 3 19 55  
 (Month) (Day) (Year)

5. SEX: Male  
 6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): —

8. DATE OF BIRTH: November 30, 1955

9. AGE last birthday: 5 yrs. 6 Months 4 Days — Hours — Min.  
 IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

## 13. FATHER'S NAME:

Watson Earl Smith

## 14. MOTHER'S MAIDEN NAME:

Stella Mae Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: None

## 17. INFORMANT &amp; ADDRESS:

Stella Mae Smith Frederick RFD 6

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

773.5  
 Immediate cause

(a) Prematurity  
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Sclerosis  
 DUE TO

(c)

Interval Between Onset And Death  
1 day

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-30, 1955 to 12-3, 1955, that I last saw the deceased

alive on 11-3, 1955, and that death occurred at 5:10 A.M., from the causes and on the date stated above.

SIGNATURE Dr. Frederick J. Heldrich (Physician or title)

ADDRESS

DATE SIGNED 12-3-55

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## DATE THEREOF

5 Dec 1955

## NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

## LOCATION (City, town, or county)

Frederick, Maryland

(State)

DATE REC'D BY LOCAL REGISTRAR 5 Dec 1955

## REGISTRAR'S SIGNATURE

Elizabeth G. Hech

## 24. FUNERAL DIRECTOR

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S.

RECEIVED

11977 **CERTIFICATE OF DEATH**

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u> COUNTY <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Frederick-Rural-R.D.#5</u>		LENGTH OF STAY (in this place) <u>Years</u>		TOWN <u>Frederick-Rural-R.D.#5</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Braddock Heights</u>		STREET ADDRESS <u>Near Braddock Heights</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>EDWARD J. A. STRUBEK</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 24, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify)	8. DATE OF BIRTH <u>June 7, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>Retired Pharmist</u> )		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-1673</u>		17. INFORMANT & ADDRESS <u>Mrs. Russell H. Yinger, Frederick, R.D.#5,</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
4. IMMEDIATE CAUSE (A) <u>Rupture Right Adrenal Gland</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Generalized Arteriosclerosis</u>						<u>5 years</u>	
STATING UNDERLYING CAUSE LAST.							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 24</u> 19 <u>54</u> to <u>24 Dec</u> 19 <u>55</u> , that I last saw the deceased alive on <u>24 Dec</u> 19 <u>55</u> , and that death occurred at <u>10:10</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Thomas L. Stone</u>				ADDRESS (Street, city, town, state) <u>463 N St</u>		DATE SIGNED <u>25 Dec 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>27 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

DEC 15 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11971

11950

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		LENGTH OF STAY (in this place) <i>1 week</i>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middletown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred. Memorial Hosp.</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>CHARLES A. SUMMERS</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>12 22 1955</i>			
<b>5. SEX</b> <i>male</i>	<b>6. COLOR OR RACE</b> <i>white</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>4-19-1885</i>	<b>9. AGE last birthday</b> <i>70</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>carpenter</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>construction</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>Martin L. Summers</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Catherine Poffinberger</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs. Marinda Summers, Middletown, Md.</i>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>1 IMMEDIATE CAUSE (A)</b> <i>6000 Uremia</i>				<i>3 days</i>			
<b>2 ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Chronic pyelonephritis</i>							
<b>3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>1953</i> to <i>22 December 1955</i>, that I last saw the deceased alive on <i>22 December 1955</i>, and that death occurred at <i>8:10 P.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>James B. Thompson</i> M.D.				<b>DATE SIGNED</b> <i>12/24/55</i> (State)			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>12-26-55</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Church Hill Cem.</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Frederick Co. Md.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>Elizabeth B. Heide</i>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Gladhill Co., Middletown, Md.</i>		<b>ADDRESS</b>	
<b>DATE</b> <i>26 Dec 1955</i>							



11951 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET (If rural give location) <u>125 East Patrick Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Wayne Edward Thompson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 10 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>—</u>		8. DATE OF BIRTH: <u>December 9 1955</u>	
9. AGE last birthday: <u>1</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Infant</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Donald Edward Fritz</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Catherine Thompson Frederick, Md.</u>				125 E. Patrick St.			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
761.0 IMMEDIATE CAUSE		18 hrs
(A) DUE TO <u>Cerebral edema</u>		
ANTECEDENT CAUSE (S)		
(B) DUE TO <u>Cerebral Anoxia</u>		?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>Infant Cord torsion</u>		?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9 am, 1955, to 10 am 1955, that I last saw the deceased alive on 10 Dec 1955, and that death occurred at 6:25 PM, from the causes and on the date stated above.

SIGNATURE <u>H. M. Power Jr</u>	DATE THEREOF <u>12 Dec 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>12 Dec 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth S. Hark</u>	24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

DEC 18 1953

RECEIVED



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-58 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11973

11952

# CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (In this place) <b>30 Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>711 Motter Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>BARBARA ANN TRUMP</b>				<b>4. DATE OF DEATH</b> <b>December 12, 1955</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widow</b>		<b>8. DATE OF BIRTH</b> <b>31 May 1870</b>	
<b>9. AGE last birthday</b> <b>85</b>		<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>House-work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Daniel Smith</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Kenney</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>711 Motter Ave., Mrs. Lewis F. Esterly, Frederick, Md.</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>260X IMMEDIATE CAUSE (A)</b> <b>Cholera 7/18/55</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 yrs.</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Cholera 7/18/55</b>				<b>10 yrs.</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1940 to 1955, that I last saw the deceased alive on Dec 12, 1955, and that death occurred at 10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>DATE SIGNED</b> <b>13 Dec 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>15 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Glade Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	
<b>DATE</b> <b>13 Dec 1955</b>				<b>ADDRESS</b> <b>Frederick, Maryland</b>			

U.S.

1955

RECEIVED

## 11978 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Frederick-Rural-R.D.#3</u>		<u>Years</u>		<u>TOWN</u> <u>Frederick-Rural-R.D.#3</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hansonville</u>				STREET ADDRESS (If rural give location) <u>Hansonville</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GUSTA</u> (Middle) <u>SAMUEL</u> (Last) <u>WACHTER</u>				(Month) <u>December</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, <del>SWORN</del> (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>November 16, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Philip Wachter</u>				14. MOTHER'S MAIDEN NAME <u>Marietta Fout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. George S. Wachter, Frederick, R.D.#, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Indiscreetly R. removal</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronicity of liver</u>				<u>48 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Myocarditis</u>				<u>48 hours</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>C</u>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13</u> , 19 <u>30</u> , to <u>Dec 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>55</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Frederick, Maryland</u>		DATE SIGNED <u>12/21/1955</u>	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Reformed Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chralesville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M.R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	
DATE <u>21 Dec 1955</u>							

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

U.S. AIR FORCE

RECEIVED

11979

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>Rural, Mr. Feagarville</i>		<i>20 yrs.</i>		<i>Rural, Mr. Feagarville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First)		(Middle)		(Last)			
<i>WILLIAM</i>		<i>WINTFIELD</i>		<i>West</i>		<i>Dec 4 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>	<i>Divorced</i>	<i>Dec. 12 1882</i>	<i>72</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Farmer</i>				<i>Employed</i>		<i>md.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John D. West</i>				<i>Butler</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>17 No</i>				<i>-</i>		<i>Mrs L. Monroe West, Fred. R. 4. Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE						<i>21 days</i>	
(A) DUE TO <i>Pulmonary Edema</i>							
ANTECEDENT CAUSE (B)						<i>10 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<i>Myocardial decomposition with Chini Passus Longueta</i>	
(C) <i>Acute Bronchitis</i>						<i>2 wks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/16</i> , 1955, to <i>12/4</i> 1955, that I last saw the deceased alive on <i>12/3</i> , 1955, and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.							
SIGNATURE		M. D.		DATE SIGNED			
<i>A. G. Brice</i>				<i>Jefferson May</i>		<i>12/5/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12/7/55</i>		<i>Linganore</i>		<i>Unionville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>6 Dec. 1955</i>		<i>Elizabeth S. Hede</i>		<i>G. C. Barton</i>		<i>Walkerville, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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11976

11980

## CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>NEW MIDWAY</u>		RURAL LENGTH OF STAY (In this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>NEW MIDWAY</u>		RURAL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EZRA DAVID WETZEL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 26 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>FEB 2-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TENANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY WETZEL</u>				14. MOTHER'S MAIDEN NAME <u>MARY NAILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>MRS EDGAR LAMBERT KEYMAR MD</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
45. IMMEDIATE CAUSE (A) DUE TO <u>myocardial failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
ANTECEDENT CAUSE(S) (B) DUE TO <u>Chronic myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) <u>Generalized arteriosclerosis</u>				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 25, 1955</u> , to <u>Dec. 26, 1955</u> , that I last saw the deceased alive on <u>Dec. 25, 1955</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. Franklin Bitchy</u>				ADDRESS (Street, city, town, state) <u>Thurmond Ind.</u>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 30, 1955</u>		REGISTRAR'S SIGNATURE <u>S. G. P...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DD HARTZLER &amp; SONS</u>			
				ADDRESS <u>BRIDGE MD</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11981

## CERTIFICATE OF DEATH

11977

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Frederick Co</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick Md</u>			
TOWN <u>Frederick</u>				TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.2</u>				STREET ADDRESS <u>R.D.2</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u> (First)		<u>PATRICK</u> (Middle)		<u>WILLIS</u> (Last)		4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT 10, 1875</u>	
9. AGE last birthday <u>80</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co Va</u>	
13. FATHER'S NAME <u>Charles F. Willis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <u></u>		17. INFORMANT <u>Henry L. Willis Frederick Co Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>156.1</u> (a) <u>Pulmonary Edema</u>						<u>1 Day</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Coronary Artery of Heart</u>						<u>1 year</u>	
(c) <u>Myocardial Infarction</u>						<u>1 week</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <u>SUICIDE</u>				PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Indonesian Road</u> (CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Md</u>			
HOMICIDE				INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Dec 20</u> , 19 <u>55</u> , to <u>Dec 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>55</u> , and that death occurred at <u>3 a</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Karl H. Lammertbaum</u>				ADDRESS <u></u>			
DATE SIGNED <u>21 Dec, 1955</u>				DATE SIGNED <u></u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Unal</u>		DATE THEREOF <u>Dec 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Yokelville Md</u>		LOCATION (City, town, or county) <u>Montgomery Co Md</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>21 Dec, 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		24. FUNERAL DIRECTOR <u>Roy W. Barber</u>		ADDRESS <u>Yokelville Md</u>	

RECEIVED

DEC 22 1955

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

11978

2411 N. Charles Street, Baltimore

11982

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Fredenck</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fredenck</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kinda-bona Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Fredenck</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fredenck</u> STREET ADDRESS (If rural, give location) <u>E. Palm St</u>	
3. NAME OF DECEASED (Type or Print) <u>ANN</u> (First) <u>SOPHIA</u> (Middle) <u>WILSON</u> (Last)		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>11/4/1875</u>
9. AGE last birthday <u>80</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nathanial J Wilson</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Sophia Albough</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT <u>Mrs Paul Rhoades</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Myocardial Decompensation</u>		
Antecedent cause(s) (b) <u>Senility</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1955, to Dec 13, 1955, that I last saw the deceased alive on Dec 13, 1955, and that death occurred at 6:20 P. m., from the causes and on the date stated above.

SIGNATURE H. Lawrence Johnson MD ADDRESS Fredenck Md DATE SIGNED 12-15-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>12/16/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	LOCATION (City, town, or county) (State) <u>Fredenck Fredenck Md</u>
DATE REC'D BY LOCAL REG <u>15 Dec. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	24. FUNERAL DIRECTOR <u>Harry E. Gault</u>	ADDRESS <u>Fredenck Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 16 1955

BUREAU V. S.